On October 31, the United Nations Security Council adopted Security Council Resolution 1325, calling on all parties to an armed conflict to take special measures to protect women and girls from gender-based violence, particularly rape and other forms of sexual abuse.

The Rome Statute of the International Criminal Court, which entered into force July 1, 2002, states that rape and any other form of sexual violence of comparable gravity may constitute both crimes against humanity and war crimes.

Since 2003, mass rape committed by members of the Sudanese armed forces and affiliated militia with the support of the Government of Sudan has been a central component of the Government of Sudan's violence and ethnic cleansing in Darfur.

Can you imagine this is the army, the militia of a country just having their way, going into camps and violating women and girls, thousands of women and girls who have been violated as a result.

Women and girls leaving internally displaced persons camp in Darfur and refugee camps in Eastern Chad to seek firewood, water or outside sources of income are often attacked and subjected to rape. My colleague already spoke to that issue. It is just outrageous that this could continue to happen.

On March 9, 2007, members of the United States-United Nations High Level Mission on the Situation of Human Rights in Darfur reported that rape and sexual assault have been widespread and systematic, terrorizing women and breaking down families and communities and that women are also attacked in and around refugee camps in eastern Chad.

Think about this: systemic, widespread, terrorizing of women and girls. Systemic. That is just something that I can't even imagine that we would continue to allow happen in another country. We know how great the impact of rape and sexual assault on women and girls in our country over time, and imagine what it would be in a country where they don't have available to them what our women and girls have available to us. Be it counseling, medical care, long-term mental health counseling, it just doesn't happen.

So I'm just so happy that the House passed by way of suspension bills today three resolutions around Sudan.

Finally, I think that what I would say at this point is that the people of America and all of these nonprofit organizations and the children across this country, women and children and students, must stand up. They must speak up about what's going on in Darfur, and you all know that old statement, that piece of speech that someone gave, and I can't think of the author, and it said, if you're quiet when they come for other people, who's going to speak up when they come for you? And that is what we should all be thinking about, that we need to speak up on behalf of the people of Darfur and say enough is enough; we're not going to have this happen anymore.

The United States, under the leadership of George Bush, who's been talking loud and saying nothing on this issue and not moving forward, should move forward to make sure that there are people and peacekeepers going into this area and making sure that these people are taken care of.

With that, I would again commend the Chair of the Congressional Black Caucus, Congresswoman CAROLYN CHEEKS KILPATRICK, for her leadership and thank her for giving me the opportunity to lead the Congressional Black Caucus message hour every Monday evening and to give us the opportunity to step up, speak out, and really shine a light on issues that the Congressional Black Caucus is concerned about and that the people of America, regardless of their color, are concerned about.

Again, thank you very much, Madam Speaker. It's always good to be leading a Special Order when you're in the chair. I thank you for your leadership as well.

Mr. CONYERS. Madam Speaker, today we recognize the ongoing loss of life occurring in Darfur. I would like to restate my unconditional support and commitment to advancing peace and security for the people of Darfur. I implore my colleagues in Congress to join me in urging the Sudanese government to take decisive action to address this tragedy. This quite simply is a matter of Life and Death and as the destruction of hope and possibilities continues to erode away at a people who are calling out for help. These atrocities continue to mount in the Sudan as our Administration continues to pump billions of dollars into Iraq and redirects greatly needed resources away from this unnecessary tragedy. The conflict in Sudan began as a genocide against tribes of small farmers in its Darfur region over five years ago. Militia groups have slaughtered an estimated 400,000 people and driven 2.5 million people from their homes. There has been an increase in civilian killings and large scale attacks in Darfur. The rape and torture of women and children remains a constant concern on a daily basis. Thousands have moved to displacement camps which contain their own level of violence with guns being readily available and tensions in Darfur continuing to grow every day. The African Union peace keeping troops who have put up a courageous fight have lacked the proper resources and manpower needed to contain the growing threat. Equipped only with light weapons, they are no match for the heavily armed rebels. They are undermanned and outgunned and in desperate need of advanced weapons and helicopters to properly engage with the Militia.

In May, Nobel Peace Prize winner and Holocaust survivor Elie Weisel called Darfur "the capital of suffering." He called on all of us to "tell the victims they are not alone." Violence continues in Darfur, as the Sudanese government attacked two internally displaced camps in the past week. On October 19, the Militia attacked the Kalma refugee camp, the largest in Darfur. Additionally, on Oct. 22, the Hamidiya camp near the town of Zalengei was attacked in a series of clashes between government troops and rebel groups. The killings of African Union peacekeepers and World Food Programme contract drivers combined with detentions of humanitarian workers in the conflict-ridden Darfur region of western Sudan are just a few examples of a deteriorating situation, which is prompting increased anxiety by those affected by the ongoing crisis, as well as by those responding to the emergency. From June until late August, the United Nations reported, an estimated 55,000 new persons had been displaced in the region—bringing the total number of those uprooted this year to some 250,000. In all, the UN estimates, 2.2 million of Darfur's 6.4 million people have been displaced, and four million are now dependent on some form of humanitarian assistance.

While almost everyone involved in Darfur policy agrees that an African Union peacekeeping force of just 7,000 troops is not up to the task, the United States has refused to send troops and, despite promises of reinforcements, has yet to secure many additional troops from other countries. At the same time, it has been unable to broker a diplomatic resolution that might ease the violence. There is no doubt that what is taking place in Darfur is genocide, and the government of Sudan and the Janjaweed bear responsibility. Congress and the Administration must support legislation to address this most pressing human rights issue. We must move beyond the rhetoric and take action to save the lives of the people who are struggling each day with this horrific conflict. We must leave politics aside and support legislation such as H. Res. 573, which recognizes and commends the efforts of U.S. advocacy groups to raise awareness about and help end the worsening crisis in Darfur; We must also support H. Res. 740, which condemns the brutal attack on African Union peacekeepers that occurred in Haskanita, Darfur one month ago today. This violent act, carried out by rebels, took the lives of 10 peacekeepers—seven Nigerians and three other soldiers from Mali, Senegal, and Botswana; and finally H. Res. 726, a resolution calling on the President and the international community to take immediate steps to respond to and prevent acts of rape and sexual violence against the most innocent of Darfur's victims—young girls and women.

We must continue to provide security and support for the courageous humanitarian workers, who risk their lives daily. Their commitment to this struggle has been exemplarily in the face of danger. We must also take this opportunity to unite and stop these crimes against humanity. We can not allow our past failures to identify genocide in places such as in Rwanda, Bosnia, and elsewhere to exist ever again.

HEALTH CARE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 18, 2007, the gentleman from Texas (Mr. BURGESS) is recognized for 60 minutes as the designee of the minority leader.

Mr. BURGESS. Madam Speaker, I come to the floor of the House tonight as I frequently do to talk a little bit about health care.

Tonight, I will be filling the leadership hour of the minority side, and I

certainly thank the House leadership for providing me the opportunity to speak to the Chamber over this hour and talk a little bit about health care, perhaps give a little bit of historical context, perhaps talk a little bit about our current situation, perhaps talk about the prospects for change in the future, talk about what principles are important to maintain in a health care system, whether it be public or private, the principles of affordability, accountability and advancements.

Madam Speaker, I hope to spend part of this hour talking about the things that I think will improve the delivery of health care in this country, regardless of who the payer is, because we are perhaps perched on a historical time.

Madam Speaker, I believe with all my heart that we are perched on a transformational time in American medicine, a time that we've seen perhaps similarities with before, perhaps three times in the last century. We'll detail those in just a moment, but it is a time like any other.

When the rapidity of the scientific information is coming at such a rate, the rapidity of scientific change is coming at such a rate, and at the same time we're poised to perhaps have a significant impact on the delivery of health care in this country by how we craft our public health policy, our health policy in this body, think about in the preceding century we had three, I believe, transformational times in the 20th century.

You think about the status of medicine in the days of the late 1800s leading up to the early 1900s, and it was not always a pretty sight. Blistering, burning, and bleeding were treatments that were not only tolerated; they were, in fact, embraced by the medical mainstream, the best minds in medicine at that time. But those heroic efforts were beginning to be supplanted by people who rigorously applied the scientific method and began to investigate as to whether or not these heroic methods were, in fact, yielding or returning a positive benefit for the patient. In fact, they found that they were not.

And at the same time, you had scientists working on concepts such as sterility, sterility during surgery, vaccinations, improvements in public health, sanitational water supplies, as well as just a decade before you had the introduction of anesthesia which, obviously, radically changed the prospects for being able to perform surgery.

□ 2045

There was also a crisis of confidence in American medicine, because there was no standardization in American medical schools. They were all over the map as far as their embracing scientific method or scientific philosophy. This body, the United States Congress, in 1910, commissioned a study that was ultimately called the Flexner Report, which detailed the problems inherent in American medical schools and how value to the patient could be improved by standardizing the training and making the training more rigorous and adhering to the scientific process.

Well, not quite midway through the century, in the 1940s, we saw, again, a transformational change occurring in American medicine. How did this change come about? Actually, there were some discoveries that preceded the 1940s by a little bit. Sir Alexander Fleming discovered penicillin in 1928. At the time, it was just more or less a laboratory curiosity that the growth of a mold in a Petri dish could inhibit the growth of a bacteria, but it was American ingenuity and American know-how that took this concept and made possible the distillation and production of large amounts of this compound.

Prior to the 1940s and prior to the intervention of American know-how, only small amounts of penicillin were available. Again, it was more of a laboratory curiosity than a useful treatment that could be made available to a broad spectrum of patients.

With the introduction of new techniques for bringing this medicine to the public, large amounts of medicine were made available, the price plummeted and, as a consequence, we ushered in the new antibiotic age in the early part of the 1940s. It was terribly significant. Many of our soldiers who were wounded during the invasion of Normandy on D–Day had wounds that ultimately would have been much more serious had infection become a problem, but now, because of the availability of penicillin, many of those infections could be treated, life and limb could be saved and spared. It was, indeed, a change that medicine had not previously seen.

There was another rather dramatic development during the 1940s, about the same time, Percy Julian, who was an African American scientist who we honored in this body during the last Congress. He didn't discover cortisone. Cortisone had previously been discovered but was only available by a labor-intensive process. You had to get it from the adrenal glands of an ox.

Cortisone was very difficult to obtain, very expensive and really wasn't available to treat much in the way of a large number of patients. It was available only as an experimental effort.

But Dr. Julian, who had experimented in biochemistry for a number of years and worked extensively with soybeans and soybean products, found a way to make a precursor to cortisone and, in fact, found a way to apply this for the commercial production of cortisone. Suddenly, this medicine, this miracle drug which had been available only in very small supply and terribly expensive, now became generally available to treat patients.

So we had the advent of anti-infective agents in the antibiotics and anti-inflammatory agents with cortisone, all of which occurred around the mid-1940s. What else happened in the mid-1940s? Of course, we were a country at war. As a consequence, the workforce in this country was severely contracted. In an effort to keep employees, what employees were available on the job, employers wanted to pay higher and higher wages to keep the employees there and keep them satisfied.

But the Federal Government, the President of the United States, President Roosevelt said, we are going to get in trouble with inflation if we are not careful, and put in place a series of wage and price controls to kind of keep the lid on this rapidly expanding sector of the economy. He felt it was justified because of a wartime situation.

Well, employers still wanted a way to attract employees, to hold employees, to keep employees, keep them happy, keep them satisfied, keep them healthy and well so they stayed on the assembly lines and stayed in the workforce. They devised a plan to offer health insurance and retirement benefits to employees that were under their employ.

Well, it was kind of controversial as to whether or not this would be something that was even available, whether or not it violated the spirit of the wage and price controls that were in place at the time, and, if it was something that could be made available, is this a benefit that would be taxed or not taxed? The Supreme Court in a historic decision in 1944 decided, number one, that this did not violate the spirit of wage and price controls. Just as importantly, they determined that these benefits provided as health insurance benefits and retirement benefits, in fact, were not taxable benefits. Thus, the era of employer-derived health insurance was born.

After the war, it continued because it was very popular. People liked that concept. They liked the fact that you, at the time you went to work, you received health insurance; so that was one worry that was lifted off of you that you didn't have to contend with. It changed forever the face of how medicine is practiced in this country, as much, I submit, as the introduction of penicillin and as much as the introduction of large-scale production of cortisone.

So we will quickly fast-forward to the 1960s. In the 1960s, again, we were seeing a big transformation in medical care, a big transformation in science, the newer antibiotics were available that could treat more and more diseases, more aggressive diseases. The whole era of chemotherapy began to be ushered in. Antidepressants were available for the first time, as well as antipsychotics, which had a profound effect on the census in psychiatric hospitals.

What else happened in the 1960s? Well, a little over 40 years ago, this Congress, at the direction of a fellow Texan, Lyndon Johnson, developed the Medicare and then subsequently the Medicaid programs to provide a social safety net for our seniors. Then, ultimately, with the introduction of the Medicaid program, it provided a social

safety net for people who were too poor to afford health insurance.

So there was greater access, greater access for the aged, for people who were disabled, and for people who historically had been not allowed into the medical system because of a poor financial situation. But, the government established for the first time an enormous footprint in the practice of medicine in that for the first time it paid for a significant amount of the practice of medicine.

Now, the current situation is that about 50 percent of the health care dollar is derived from the United States Congress, from the Federal Government. The other 50 percent is not all private pay; it's private, commercial insurance as well as people who pay bills out of their pocket, self-pay individuals, and I will actually include the 4.5 million people that own health savings accounts. I would include them in that group as well.

Of course, there are people who just simply do not pay the bill; there is bad debt. There is also charitable care that is given by a doctor or a hospital to a patient and no payment is expected.

Now, the big question before us is can this hybrid system that has just sort of grown up, can this hybrid system be sustained? The tension that exists within this system, I think, creates a dynamic for continued change and for medicine to continue to evolve and continue to reinvent itself.

But, as I said, we are on the brink of a time of transformational change. I believe that in the early part of the 21st century we will see and we have seen changes in medicine as a result of cracking the genetic code. Genomic medicine, which was a phrase that I wouldn't even have been aware of during medical school or residency, now is part of our regular parlance.

Diseases that used to be treated only with surgery are now treated with medicines. There are going to be vast changes on the horizon as far as the treatment of disease goes as we begin to understand more about how the human genome affects the course of health and disease, how we can intervene earlier at a lower cost to prevent disease and, quite honestly, extend life over time.

But, we are also poised at a time where it looks as if, because of frustrations with the current system, because it doesn't provide all of the coverage that we think it should to every person who we think needs it, we are poised here in this Congress to begin debating an ever greater expansion of the Federal Government's role in health care in this country.

It will ultimately be up to us to decide is this a good thing or a bad thing. Since we live in a representative Republic, it will be up to the American people to decide is this something that we want to see more of or less of. They will, of course, register those thoughts with their votes, not only in the 2008 election but in the 2010 election.

I would submit to you that it is important that we keep in mind really where the fundamental unit of production is in this vast medical machine that we have in this country. What is the widget that is produced by the vast medical machine?

Well, my impression is that it is the interaction that takes place between the doctor and the patient in the treatment room, whether you like to say the operating room or the emergency room, but, nonetheless, it is the interaction between the doctor and the patient. That is the fundamental unit of production in American medicine. How do we interact that?

Well, my opinion is anything that will deliver value to that interaction is one of those things that we ought to encourage. Anything that detracts from value or anything that serves to drive apart the doctor-patient interaction is something that may be seen as pernicious. It's all about empowering the patient and not an insurance company, not the Federal Government. We need to focus on those policies that will bring that power back to the patient, will bring that value back to the doctor-patient interaction.

A lot of people would argue that we need health care reform. In fact, remember, that was a big argument in 1992 in the Presidential election and in 1993, the year that followed, and then, ultimately, nothing was accomplished and the situation stayed as it is. But they kept talking about health care reform, health care reform, health care reform.

Well, reform is what you need if the system is working just jim-dandy, just working extra special well, and you only need some marginal changes around the edges. But since we are upon a time of great scientific advancement, changes in how we handle information technology, changes in how we even approach medicine, the whole era of personalized medicine is just a little bit over the horizon, and we may well see that in my lifetime, certainly in my children's lifetime.

Medicine is on the cusp or the threshold of some big changes. Is reform going to be enough to enact the social policies that we need here in Congress as well as permit those transformational changes that are occurring in science and occurring in the delivery of medical care?

Now, I would submit that only by keeping a portion of the free enterprise system involved in health care, only by that method are we likely to continue to generate the kind of instability we need in a system in order to foster change, in order to foster growth, in fact, in order to drive that transformational process.

If, suddenly, we are at complete equilibrium and there is no tension on the system anymore, what's going to cause it to grow? If, in fact, we devolve to a single-payer system where the Federal Government picks up the entire tab for medical care from cradle to grave, and there are some people who think that would be the correct response, the correct way to go, what will change? What will be the impetus to change? What will be the reason to change anything about medicine?

What you see today, if you enact that system, is what you will see 20 years from now, 40 years from now, 60 years from now. The transformational change that I think will be responsible for some of the greatest gifts that medicine could give to humankind, suddenly the spark, the spark of incentive would be removed and we would have a steady state that would be well paid for, a lot of people would be well taken care of, but the improvements, the advancements would be lacking in such a system.

If we move toward a system that is more patient driven, rather than one that's driven by insurance companies, rather than one that's driven by governments, I think we will usher in that new era of transformation in American medicine.

During the course of that, we have got to keep health care affordable. We have got to keep the monitor on the person in the middle, the person who acts as that barrier between the doctor and the patient, what we describe as a middleman. We have to keep that very close tab on what's happening in that arena. That's one of the things that prevents a patient from knowing the value of care they receive. It's one of the things that prevents a doctor from knowing how much the care they are ordering is going to cost or what burden that patient will have to bear. We have anesthetized everyone by putting a third-party payer in the middle of that mix.

Now, questions do come up as to how we bring about those changes and not obstruct changes that we want to see happen, but, again, keep in mind things like the advancements in medicine that are going to occur as a result of discovery of the human genome and further elucidation of the human genome, concepts like rapid learning. When I was in medical school, we all just worshipped at the altar of the double-blind crossover study in order to prove that something was effective or not.

But we live in a time when computational speed and capability is so vast, and the speed of learning is so fast, that, you know, it may no longer be as necessary as it once was to select the correct sample size and go out and do all the statistical tests. We can just simply monitor everyone, everyone who is on Lipitor, everyone who is on a statin, see what their complications are, see what their health benefits are that people who are on statin live as long or longer than a closely matched age and gender-matched group of individuals who are on no such therapy. We can begin to develop those concepts, and the data is there and will accumulate rapidly because of advances that are being made in health information technology.

□ 2100

That's the way that, ultimately, we're going to be able to curtail some of the costs of taking care of chronic diseases and, in fact, beating chronic diseases; and I would include cancer in that group. And above all, we do have to ensure an adequate workforce to be able to provide that care.

Now, I alluded a few minutes ago at the point of transformational change, but we also run the risk of getting caught up in transaction. You know, if you think back to 1993 and the changes in health care that were discussed at the time, we really weren't talking about any kind of health care change. We were talking about change in the administration of insurance policies.

As a result, since we got caught up, in this body, in the transactional, we forgot about the transformational. And again, as a result, there really wasn't much happened, except we left the field essentially empty, and HMOs and managed care came in, took over a large market share. And that was the time, at least in my experience as a physician, when some of the worst excesses of HMOs and managed care occurred: care being denied, patients being put out of the hospital too soon. And then Congress was in a very reactive mode: you've got to have this many days after delivery, this many days in the hospital after a mastectomy.

Well, that clearly wasn't the way to go about it, but that is the risk that we run if we focus on the transactional and forget the transformational. So all three things, affordability, accountability and advancement, must be considered and must be given equal weight in any change that comes about.

Within the concept of affordability, it's really not how much money you spend; it's how you spend it and are you getting value for the dollar that you spend in health care. And I would circle back and bring it back to that interaction between the doctor and the patient in the treatment room. How do we deliver value to that fundamental unit of production of medical care? And if a policy that we propose delivers value, then that is something that really should be looked at and one that should be carefully debated and perhaps enacted into law.

But if you look at that fundamental interaction between the doctor and the patient in the treatment room and it is fundamentally deleterious, well, maybe that's something that we should not be doing. We see examples of this within the insurance environment all the time.

And I would use the bill that we voted on last week, the State Children's Health Insurance Program. Good things in the bill, but some bad things in the bill. Some of the bad things is we tend to take children off of private health insurance and move them onto the State's Children's Health Insurance Program; and we do that for successive, for families who earn excessively larger and larger incomes.

Now, we can argue what the top line was; the top line reported in the bill was $60,000. But on the floor of this House, the chairman of the Energy and Commerce Committee admitted to me that States could disregard $20,000 income for housing, $10,000 in income for clothing, and $10,000 in income for transportation. We're up to over $100,000 with the income set-asides that some States could develop.

Well, what's going to happen to taking all these children off of private health insurance, perhaps coverage that the employer provides their mom and dad and moves them on to an SCHIP policy? Many pediatricians around the country find that the reimbursement for a State Children's Health Insurance policy in their State reimburses at a fundamentally lower rate than the private plans. Even though the private plans aren't great, they're better than the State Children's Health Insurance policy.

So what if a pediatrician's earnings or gross bookings for their practice go down by 30 or 40 percent on that segment of patients? Well, if you make that segment of patients successively larger, it's going to be more and more difficult for them to make up that gap; and what they will do is what doctors have always done: they'll open a little earlier, they'll stay open a little later and they'll kind of squeeze a few more patients into every hour.

Now, I ask you, is that a way to drive up the value in that doctor-patient interaction? I don't think so. I think if you squeeze more and more patients into that hour, if you increase that doctor's work day so they're having to make decisions on less and less rest with more and more stress, we are ultimately likely to negatively affect the value of that doctor-patient interaction.

So certainly that's one aspect of the bill for me that was extremely important for us to fully evaluate; and, unfortunately, we didn't get to evaluate it. We didn't get to debate it. We didn't get to do it in committee. We didn't get really to debate it on the floor. It was kind of an up-or-down vote: take it or leave it. And that's fine if that's the way you want to run things. But for me it was a fundamentally flawed idea because it damaged the value of the doctor-patient interaction.

Other programs that may improve the doctor-patient interaction, I'm aware of a large employer in my district back home, school district, to be precise, that has a number of employees under their insurance policy that provides a $20-a-month premium reduction for anyone who undergoes some pretty basic screening, blood pressure, weight and doing a little blood work. So there's a $250 value returned to the enrollee in the health plan over a year's time. So obviously that's a value. It's a value to the insurance company because now they're able to identify perhaps that silent person with a cholesterol up to here or a blood sugar that's an undiagnosed and unmonitored diabetic.

They can identify those individuals; and if the individual is desirous of help, they can get them into the proper type of care that will lower the likelihood of a heart attack with the attendant time in the intensive care unit, perhaps coronary artery bypass grafting, perhaps even the risk of sudden death or the complications of untreated diabetes, problems with eyesight, the problems with circulation, leg amputation, all of the kidney disease that goes along with untreated diabetes. Perhaps we can begin to get a handle on this earlier in the course of the disease so that the disease course may be modified and ultimately less costly.

Well, I would submit that that insurance company has found a way to deliver value to the doctor-patient interaction; and, in fact, I would think that's behavior that this body would want to encourage, not discourage, amongst private insurance players.

But these are just two examples of where value for the doctor-patient interaction can be increased or decreased. And as a consequence, when I apply that test to any health care policy, my decision about that, whether or not to support that health care policy, is likely to be based on the fundamental question, are we delivering value to the doctor-patient interaction? If the answer is yes, that's a program that's worthy of further study, debate, and perhaps enacting. If the answer is no, then it becomes fairly easy for me to say that's not a policy that I would be inclined to support at the present time.

Now, one of the things we move on to or other aspects of affordability that we should talk about, I did allude earlier to the fact that there are now, according to recent data that was released last April, 4.5 million people who are covered under health savings accounts. That's up about a million and a half from the year before. And, certainly, while it is not a vast segment of coverage, the reality is we could cover a great deal more people who are uninsured if they just simply knew about these products.

In the mid-1990s when I went to look for an insurance policy for an adult child, it was just almost impossible to get a private individually owned insurance policy for someone in their mid-20s. No one wanted to talk to you about one single policy. We won't even discuss it unless you've got a group of five or 10, and then we're going to charge you a great deal for that. Now, I was ultimately able to get insurance for that individual.

But what a change 10 years later. Any individual getting out of college today, mid-20s, off their parents insurance for the first time in their life, maybe they want to go start a business. Maybe they haven't quite found that right job yet; but rather than going without health insurance, they now have an option. They can go to the

Internet and in the search engine of choice type in health savings account and very quickly they'll be taken to sites that will provide them a vast array of choices in high deductible insurance policies. These policies are typically paid for with after-tax dollars, which is a limitation, I admit, and one that this Congress should take up and deal with. But oftentimes we're talking about individuals who are not in the higher income earning brackets or perhaps pay no Federal income tax at all. So the fact that it's not a tax deductible expense is not of great import to them.

But the fact that you can get a high deductible insurance policy that, with a $2,000 to $5,000 deductible that ranges in price from about $55 a month to $75 a month, well, that's a pretty significant savings over what we typically associate with the cost of insurance, which is obviously much greater than that.

So that young individual who's just starting out doesn't need to start out life without insurance coverage. It's not something that they need to forego. Yeah, it's a high deductible policy, so guess what? If you go in for a flu shot or you go in for some relatively minor difficulty likely as not that's going to be something that will have to be borne by the individual.

But if that individual has a catastrophic event, a motorcycle accident, an accident or pregnancy and requires prolonged hospitalization, that hospitalization is covered after the deductible is met. And how powerful is that to be able to put that type of protection in the hands of a whole segment of society that 10 years ago had no choice at all, no option. You just simply cannot buy or find insurance no matter how big a check you're willing to write, because I was willing to write a big check to get insurance coverage at that time, but it just wasn't available. Ten years later it's readily available. It's up on the Internet. And because of competition on the Internet, we've driven the price down, so affordability obviously has improved.

Now, the other great things about a health savings account is you can put money away. If you do pay taxes, you can put away money with pre-tax dollars, put money into essentially a medical IRA, or a health savings accounts. You can actually begin to accumulate dollars in that health savings account. And the good news is that over time, if that money is not used for medical expenses, it can only be used for medical expenses, but if it's not used, it doesn't go back to someone else at the end of the year. It doesn't even go back to the Federal Government if you die too soon. That money is yours. It is yours to use for your health expenses, or it is then delivered on to your heirs and assigns if you meet an untimely demise, but that money is yours. It doesn't belong to the Federal Government. The money you put into that health savings account stays under your command and control for the rest of your life as long as it is spent for health care expenses.

So you can see, even a young individual who doesn't have the financial wherewithal to contribute the full amount, say the $2,000 or the $5,000 every month to a health savings account, still can put some number of dollars away that will grow over time. And since we're talking about young individuals, well, the time value of money comes into play. And if you begin such an account when you're 25, by the time you're 65 and ready to face retirement, there may be a significant accumulation of dollars in that account. And the good news is there is no one can take that away from you.

Now another thing that we've worked on in this Congress and something that I would argue would be a positive in the values section for delivering value to the doctor-patient interaction are what are called association health plans. Now, association health plans by themselves are not going to drive down the cost of the, or the number of the, uninsured; but they will help control the ever-rising cost of health insurance which, of course, is what drives a lot of small businesses out of the business of providing health insurance. So association health plans have been voted on in the two previous Congresses several times since I arrived here in the beginning of 2003.

And the concept is pretty simple. It just says small businesses can kind of group together to get the purchasing power, the purchasing clout of a much larger organization and use that ability to aggregate themselves to get a better deal with an insurance company, to get a better deal in providing insurance to their employees. So if you have, say, a group of Realtors, a group of dentists offices, for example, a group of chambers of commerce employees, you can put this group together as long as they have similar business models. That's why the term ''association'' is used. They can be put together to go out and purchase or to make bids on the commercial insurance market and, again, get a little bit more of that purchasing clout that large organizations have.

And one of the reasons that association health plans have been contentious in this House is because for them to be effective, particularly in medium and small-sized States, you've got to have the ability to go and take in a group of people that may cross a State line. Now, a State as big as Texas, which at one time was its own country, that's not as big an issue. But still you will get a better economy of scale if you are able to draw in more people into this association that then goes out and buys insurance.

For whatever reason, we passed it in the House, three or four times in the last 4 years, but unfortunately it never did pass in the Senate. They had Senator ENZI, who was at the time chairman of the Senate Health Committee, make a good run at it last year, got all the principals in the room and tried to get them to craft an agreement on that, but ultimately was not able to get that done. And that's a shame, that's too bad because again this is one of those things that would fundamentally deliver value to the doctor-patient interaction because it would hold down the cost, the ever-increasing cost, bend that growth curve a little bit on the increasing cost, the ever-increasing cost of health insurance, and allow more people to keep and retain their insurance coverage.

Now, the President brought up in his State of the Union message here last January, and it's been talked about on and off again over the past six to eight months, the issue of equal tax treatment for employer-derived insurance and insurance that's owned by the individual. We've really not made any great progress, but I do believe the concept is one that's worthy of study, that's worthy of debate in this House. I already alluded to that fact a little earlier in the talk that once you have the employer-derived insurance as a pre-tax expense, that alters the playing field and it, in fact, encourages the use of that type of insurance and maybe even encourages the use of that type of insurance a little too much.

□ 2115

It encourages people to be overinsured because, look, I can't really pay you any more without distorting my salary structure but I will give you this more generous insurance package. And as a consequence, more insurance benefits are added to that person's benefits package, and it may, in fact, be more insurance than they actually need. So they are paying for something that they don't actually need.

On the other end of the spectrum, you have the individual who is out there pricing insurance now in the private market, and perhaps they do earn enough money to pay income taxes, and it would be great to extend or expand their purchasing power for that insurance by allowing them to pay for that with pretax dollars.

There is going to be a lot of debate on that over the next several years, I expect. In my mind, it is the only sane and smart way to go to, again, decouple the insurance product from the tax code and kind of put everybody on an equal footing. It's either deductible for everyone or not deductible for everyone. But let's put everyone on the same playing field there because only in that way will we get true equity and only in that way will we get the demand for the type of products that, again, ultimately will have the competitive forces that will push the price down. And after all, the kind of competition that is available on the Internet, the same type of competition that's available now with health savings accounts, and since they are after-tax items anyway, they are not under the same restrictions, but to get that same type of

competitive influence from pricing on the Internet that will help keep the cost of health care coverage more affordable for more people. It's kind of analogous to the people who sell car insurance and who say 15 minutes can save you big bucks on your car insurance if you are willing to invest 15 minutes on a telephone call to a particular insurance company. They have done a lot of clever things with their advertising with animated lizards and unfrozen cavemen and the like, but the reality is they have taken the concept of the type of competitive edge you can get by utilization of the Internet with car insurance. If we had the same ability to do that with health insurance, how much better would that be? Because we could drive the price down, because now people would be competing with large volumes, large numbers of patients. Now companies would be competing with large numbers of patients, and, in fact, I think we would see an improvement on the price structure rather than this continued year-after-year increase in prices and this continued year-after-year of picking only the people that we want to insure and leaving others out. This is a way of broadening the base and lowering the rate. We liked that concept in our tax policy; we should like that concept in our insurance policies as well.

Madam Speaker, mandates are another issue that will come up from time to time. The health care program that was popularized in the State of Massachusetts, very famously, depends upon an individual mandate. It is your obligation and responsibility to have insurance, and you will have insurance or we will buy it for you and charge you for it. If you don't want to pay us, we will take that money out of your State income tax refund that you are due at the first of the year. So that is one way to get people to buy insurance, to be sure.

Now, in 1993, when the Clinton health care plan was discussed, they talked about employer mandates: We're going to require every employer to participate in an employer-derived health insurance program or they are going to have to pay a large amount in order for their employees to get coverage elsewhere.

So employer mandates and individual mandates are certainly techniques that have been tried in the past, and we may see them tried again in the future.

State mandates are where a State says any insurance policy that is written in the State, you have to provide coverage for these items. It varies from State to State. Some States are quite generous, and as a consequence, their insurance rates are high. Some States are more spartan, and as a consequence, their insurance rates are more reasonable. But State mandates, individual mandates, employer mandates, in my opinion, have the ability of driving up the cost and limiting the care because they remove the competitive influences that otherwise would be brought by the competition that's available in the open market and just keeping free enterprise involved in medicine.

I guess the counterpart to mandates, for all its faults and for all of the sort of anguished discussion that we had about Medicare part D over the past several years, Medicare part D now provides pharmaceutical benefits, pharmaceutical coverage to 90 percent of the Nation's seniors, and it does so with a 90 percent satisfaction rate. And there is not a mandate in the program. And how do they do it? They provided programs that people actually wanted. That would be a novel approach. Instead of a mandate, you make something that is marketable. You make something that's desirable. You make something that patients and families are going to say that's a good idea and it's reasonably priced and I am going to do that. Mandates, on the other hand, tend to drive things in the other direction. And ultimately, although there may be a transient reduction in price long term, it has a negative influence on price and causes prices to inflate and increase over time.

Madam Speaker, I can hardly come to the floor of the House and talk about changes in our health care system without at least briefly talking about changes in the way the medical justice system is handled in this country. And the reason that it is so important to me is my State, my home State of Texas, changed the nature of the argument 4 years ago and since then has been reaping the benefits of fundamental and sound medical liability reform.

Now, the Texas legislation that passed in the legislature that convened in 2003, and subsequently we had to undergo a constitutional amendment in September of 2003, it provided a cap on noneconomic damages. The so-called Medical Injury Compensation Reform Act of 1974, as passed by the State of California, was adopted and modernized in the Texas plan. But it was a Medical Injury Compensation Reform Act-style reform that was done in my home State of Texas.

Now, caps on noneconomic damages out in California in 1975 were set at $250,000. In Texas, with the passage of this legislation, there was a cap set at $250,000 for a physician if the physician was involved; $250,000 set for the hospital if a hospital was involved; and $250,000 for a second hospital or a nursing home if one was involved. So there was an aggregate cap of $750,000. At the same time, there was no cap placed on actual damages, real damages, that were sustained in a medical liability suit and no cap placed on punitive damages if those were awarded by a judge in a medical liability suit.

The result of all of this was that a State that was in turmoil, a State that was in chaos in the year 2002, today is eminently stable when you talk about its medical justice system because of these commonsense reforms that were enacted back in 2003. The benefits that we have seen for my old insurer of record, Texas Medical Liability Trust, my medical liability premiums had been increasing by double digits every year, year after year for about the 4 years before I concluded my practice and came to Congress. The very next year after the passage of this bill in 2003, prices dropped. They dropped 12 percent. They have continued to drop. So the aggregate reduction in premium prices over the 4 years since this passed has been 22 percent for physicians insured under the Texas Medical Liability Trust. And that is in addition to double-digit increases that were happening every year up to 2003. Now we have had a 22 percent reduction. That's a significant change.

One of the most important things, though, was the number of medical liability insurers that existed in the State of Texas had gone from 17 down to two. You are not going to get much in the way of a competitive edge if you have only got two people willing to write medical liability insurance in your State. So by the start of 2003, we were truly in crisis with the fleeing of medical liability insurers from our State.

What happened after the law passed? The insurers started to come back in. Now, many of them wanted to come back in and say, we're going to have to charge you more money because Texas is still an unproven deal and we're not sure we want to come in at the rates you are going to set. But Commissioner Montemayor, who was then the Commissioner of Insurance in the State of Texas said, if you are going to come back in, you're going to come back in at reasonable rates. And as a consequence today, I'm not sure of the top number of Texas insurance companies, but certainly above 15 and may well be above 20 insurance companies that have come back to the State, and, most importantly, they have come back without an increase in their rates.

One of the unintended beneficiaries of this reform was the smaller not-for-profit hospital in the State of Texas. Smaller and medium-sized hospitals, self-insured, they had to put a lot of money away against a possible bad outcome in a court. With the passage of this law and with some return of sensibility and stability to what their actual outlay may be if they lost a case, smaller hospitals and medium-sized hospitals were able to take some of that money that they had put away in accounts to guard against a possible adverse finding in court, and now they were able to take that money and use it for capital expansion, nurses' salaries, the kinds of things you want your smaller not-for-profit hospital to be doing in your small and medium-sized community.

So it was a very big boon not only to physicians but also to hospitals. And, again, I would submit is that a win or a loss for someone who wants to deliver value to the fundamental doctor-patient interaction in the treatment

room? Obviously, it's a win. We have more doctors coming to the State. We have so many doctors coming to the State, the Texas State Board of Medical Examiners can't keep up with the pressure, with the demand on new licenses for doctors who want to get licensed to practice in Texas. So that is a good thing. Texas as a whole has been underprovidered, if ''providered'' can be used as a verb. Texas as a whole has been underprovidered for some time. The national average is 260 doctors per 100,000 population. Texas sits at about 186. But the situation is improving month over month because of some of the commonsense changes we made in medical liability insurance.

And one last thing I would add. If I'm from Texas and we've already done this, what do I care about the rest of the country that their medical justice system perhaps remains with the scales uneven and tipped to one side or the other? Well, the reason I care is because now, as a Member of Congress, we have to deal with the Federal budget every year. We have to decide how much money we are going to give Medicare and Medicaid every year. Consider this: A study done back in 1996 at Stanford University looking at the cost to the Medicare system for treatment of heart disease, the additional cost for the treatment of heart disease when factoring in the cost for defensive medicine, back in 1996, that cost was calculated to be just under $30 billion. Well, that was 12 years ago. I rather suspect that number would be higher today if anyone went back in and recalculated those figures. So it is significant. That is practically 10 percent of the money we budget every year, the money we appropriate every year to pay for the Medicare system. It is a significant savings to the Medicare system if, in fact, we can capture these savings.

Just the Texas bill alone introduced in the House of Representatives was scored by the Congressional Budget Office as saving $3.8 billion over 5 years just with the language of the Texas bill, to say nothing of what it would do on putting negative pressure, downward pressure on the cost of defensive medicine. And $3.8 billion is not a big figure when we talk about money up here in Congress. It's usually tens or hundreds of billions of dollars. But I have got to tell you what, $3.8 billion is real money, and in a year where we are scratching around trying to find every dollar that we can, that $3.8 billion is significant. And, again, I, frankly, do not understand why the House wouldn't consider taking this up, because this is a commonsense solution to a problem that vexes many States around the country.

And perhaps one of the even more pernicious effects of the medical liability crises in some States is the fact that it directs the best and brightest of our young people in a career path other than medicine. If I am going to spend all that time in school, if I'm going to accumulate all that student debt, and then when I get out, I have got to pay these high liability premiums and you go to court and they make you look like a bad guy, I don't think I want any part of it. It does have a negative effect on attracting the best and brightest into our physician workforce.

The physician workforce is important. I want to talk about that in greater detail. But just consider this: A residency program director out of one of the big hospitals up in New York a few years ago, when I asked her, ''Does the medical liability crisis impact your residency training program at all?'' she told me that, well, currently we are taking people into our residency program that we wouldn't have interviewed 5 years ago.

□ 2130

In other words, the pool of available applicants for their residency program had contracted because of the chilling effect, the negative effect of the medical liability insurance in that State. And these are our children's doctors; these are our children's children's doctors. I fail to see how the advancement of medical care is furthered by allowing policies that have that type of an effect on our physician workforce.

But let's talk a little bit about the physician workforce in the time that remains because this is another important part of where we go with health care reform, health care transformation in this country. And three bills that have recently been introduced, H.R. 2583, H.R. 2584 and H.R. 2585, deal with the problems surrounding the physician workforce.

Now, just a little bit less than 2 years ago, Alan Greenspan, as one of his last trips around the Capitol, came and talked to a group of us one morning. And a question was posed to him: What do you think about Medicare? Are we ever going to be able to pay for the unfunded liability of Medicare in the future? And he stopped and thought for a moment and said, Yes. I think when the time comes Congress will make the hard choices, make the hard decisions, and, indeed, we will be able to salvage and pay for the Medicare system. And he paused for a moment and then went on to say, But what concerns me more is, will there be anyone there to deliver the services when you require them?

And that, Madam Speaker, is a crucial point in this discussion. And that is the point behind the three bills that were introduced earlier this year to create incentives for hospitals to provide residency programs, to create incentives for medical students to go into medicine in the first place and, finally, to encourage physicians who are more mature in their practice to stay in their practice.

Creating more residency programs. There are some hospitals in the country that would welcome a residency program. They have the patient load. They could get the accreditation from the American Council of Graduate Medical Education, but the barrier for entry is just simply too high, the cost of starting a residency program is too high.

So this bill would provide loans to hospitals to begin residency programs where none have existed in the past, particularly in fields in high-need medical specialties in medically underserved areas, things like general surgery; things like family practice; things like obstetrics and gynecology. This would be the subset of residency programs that would be encouraged with this legislation.

And, as a consequence, since it is a loan program, the money would be paid back and over time would recirculate so more and more programs could be added to the Nation's training programs, particularly, again, for high-need primary care specialties in medically underserved areas.

H.R. 2584 dealt more with the younger individual who is either in medical school or perhaps thinking about a profession in health care. And this bill would provide incentives, it would provide scholarships, it would provide loan forgiveness, it would provide tax relief for individuals who, at the time of their conferring of their degrees and the beginning of their practice, would agree to practice in areas that are medically underserved and, again, in high-need specialties.

Now, this concept is actually an older concept. It was around when I was in medical school, but we need to modernize it for the 21st century.

And what really brought it home for me was visiting the gulf coast area after Hurricane Katrina. So many doctors had left, and so many more doctors were contemplating leaving. How in the world are they ever going to maintain a health care workforce in that part of the country unless they grow their own doctors in place? This is a way to allow that to happen, and of course there are other medically underserved areas around the country that might benefit from this as well.

Again, back in my home State of Texas, the Texas Medical Association puts out a periodical called ''Texas Medicine.'' This was the cover of their March issue, which raised the specter or the question: ''Running Out of Doctors.'' And these two bills were largely inspired by the work done in this article.

And one of the concepts that was put forward in this article was that medical residents tend to stay where they train; they don't go very far. The fruit doesn't fall very far from the tree. So a medical resident who trains in a town is likely to set up practice within 50 or 100 miles of that town. That is the concept behind setting up these residencies in smaller and medium-sized communities, smaller hospitals that have the need and have the patient load that will allow for the training and teaching and allow those physicians to stay in that practice area.

Well, you might ask, how does this deliver value to that doctor-patient

interaction that I've talked about several times tonight? Well, there are several ways. Number one, in just having the availability and the access of a physician. You can't deliver value to the doctor-patient interaction if you don't have a doctor there to interact with the patient. So that is certainly one very fundamental way that it can improve it. But another way, and perhaps a less tangible way, is if a doctor goes into practice within 50 miles of where they did their training, what do they know about that place? Well, they know the community. Their family, their wives and their children are probably going to be more comfortable in that community, so there is increased job satisfaction that the doctor will have in that community. I'm sorry, I should have said wives or husbands would have in that community. So there is increased personal satisfaction.

But the other thing is, you know the doctors in the area, you know who's good and you know who's not so good. Referral patterns that are established during a 3- or 4-year residency can be continued. And this is the additional value that this type of training will bring to our young physicians in the State and allow them to be better physicians when the time comes for them to begin their practice.

The final bill, 2585, deals with a problem that we've had in this Congress for as long as I've been here, in fact, before I got here, and that is the problem that we have with reimbursing physicians in the Medicare system. The current Medicare system of pricing is one that is not based on any sort of reality. Hospitals, drug companies, HMOs each get sort of a cost-of-living adjustment every year for their funding sources; but physicians, for whatever reason, don't get that cost-of-living adjustment. They don't get what's called the Medical Economic Index. What they get is called the Sustainable Growth Rate Formula, which generally pushes their reimbursement rates down year over year. And over the next 10 years time, the budgetary projection is for physician payment rates for Medicare patients to be reduced on the order of 30–38 percent. Well, that's untenable. No doctor can continue to practice; they can't even plan for their practice. They can't plan for hiring; they can't plan for the purchase of new equipment all of the time they're laboring under that type of restriction.

2585 would repeal the Sustainable Growth Rate Formula in 2 years' time. It resets the baseline for 2008 and 2009, which does allow for a positive update for physicians in 2008 and 2009, with no smoke and mirrors, no fancy footwork. It is just something that could be done.

And then we aggregate all of the savings that accrue to the Medicare system because we are doing things better, cheaper, and faster in the Medicare system currently. As a consequence, that savings can be used to offset what is described as the cost of repealing the Sustainable Growth Rate Formula over 10 years' time.

Consider this, the Medicare Trustees Report from last June said that the bad news is Medicare is still going broke, but the good news is it's going to go broke a year later than we told you last year. The reason for that is 600,000 hospital beds were not filled last year because doctors are doing things better in their practices, they are keeping patients out of the hospital, they are doing procedures in an ambulatory surgery center; and as a consequence, the overall cost price pressure on the Medicare system has reduced. The problem is that doctors don't get to have any credit for that reduction. It all goes to the hospitals, drug companies, nursing homes and HMOs, not to the part B of Medicare, which is, after all, where physicians are paid.

We need to change this. We need to make those savings only attributable to part B. And as a consequence, we can drive down the cost of repealing the Sustainable Growth Rate Formula. And by postponing that repeal for 2 years' time, but at the same time providing a positive update for 2008 and 2009, I believe we have a system in place that can be a win-win for Congress, for doctors, and for the American patient, the Medicare patient, who has increased difficulty with finding a Medicare physician.

Two other proposals in that bill, 2585, would be to provide positive updates for doctors who voluntarily improve information technology in their offices. We all know this is something that is going to have to happen. This is something that is going to have to occur. Let's give a little bit of a positive update, a little bit of a positive bonus. Yes, patients who aren't in the Medicare system will also benefit from that, but we're not getting a tremendous amount, about a 3 percent bonus per year for voluntary improvements in health information technology.

Let's also make available for physicians who voluntarily report quality measures, let's also make a positive update available for them as well. And the consequences of that is people will begin to focus on the quality aspect if you just simply make a physician aware of what their expenditures in the Medicare system were for the past year. That information is confidential. It's not something that's published; other people aren't aware of it. But doctors tend to be relatively competitive, and if they have that number available to them, they are likely to behave in a way that will try to drive that number down. Doctors are goal-directed, doctors are competitive, doctors want to be the best at what they are. Well, let's give them the data and see if they can't compete on that level.

The other thing is I think we need to make that information available to the patient as well: What did it cost the patient to provide for the treatment over the cycle of care for the past year? And, again, these are less defined, but equally important, ways we can begin to deliver value to that doctor-patient interaction.

The health information technology is so important. Many doctors are sitting on the sidelines right now. It's like buying a VCR in the mid-1980s: Do you go with Beta or VHS? And it's hard to know what the technology is going to look like in 5 years; and the person who guesses right will be rewarded, the person who guesses wrong will be penalized.

So there is a lot of tension, a lot of nervousness out there when you talk to physicians' offices. And there is no question about it, these things add a lot of time to the doctor's day, time that is not readily compensated in any other formula. So we need to consider adding that positive update, such as was done in H.R. 2585.

Well, Madam Speaker, we cannot rise to the transformational change required in this country without keeping the best doctors involved and without incentivizing and training the best doctors for tomorrow. This is going to require a near-term, a mid-term and a far-term, a long-term strategy. We will not be able to master the transformational changes and challenges without America's best and brightest still involved in the teaching and in the practice of medicine.

This is a bipartisan issue. It doesn't affect only one side of the aisle. It doesn't only affect the other side of the aisle. It requires each of us to work together.

Madam Speaker, I will submit our congressional approval ratings right now are at historic lows; and the reason they're at historic lows is not for the reason that most people think up here. The reason they're at historic lows is because we won't work together to get a single thing done for the American people, and this is one of those things that they want done.

Now, I left my beloved profession a little over 4 years ago to come and serve here in Congress. I didn't come to just sit and watch as things happened and things were brought to us by other people. I came to be actively involved in the process, and I intend to remain involved in the process.

I have outlined numerous solutions here tonight. I am grateful to the leadership on my side for giving me the opportunity to talk about these things and would only submit that there is a great deal more to discuss, and there will be more to come later.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. CARNEY (at the request of Mr. HOYER) for today.

Mr. GENE GREEN of Texas (at the request of Mr. HOYER) for today.

Ms. KILPATRICK (at the request of Mr. HOYER) for today.

Mr. KLEIN of Florida (at the request of Mr. HOYER) for today.